REFERRAL FORM Date_____

Ascend Health Center
Rise above emotional and physical pain

Please send completed form to: Fax # 833-974-2062 or Email: NewPatients@AscendHealthCenter.com // Attn: New Patient Referral

REASON FOR REFERRAL: ☐ Med Management ☐ Treatment Eval ☐ Other _____

Patient Name_____

DOB _____ ☐ Male ☐ Female

Phone _____ ☐ Home ☐ Cell (☐ consent to text messages)

Email _____

Insurance Information: (Provide copy of Insurance Card)

Insurance: _____ Member ID: _____

Policy holders Name (if different from patient) _____

Referring Provider:

Provider _____ NPI _____

Phone # _____ Fax # _____

Diagnosis:

Treatment Resistant Depression _____ Date of Dx _____

Other Dx _____ Date of Dx _____

Is patient currently in therapy/ counseling? ☐ Yes ☐ No

If yes, Name & Number _____

Provide a list any Failed Medication Trials (include doses & dates) or write N/A

_____

Most Recent Clinical Notes (attach if more space is needed), this information is required for appointments, treatments, or prescribed medications.

_____

_____

****Please include demographic information, along with recent clinical notes or letter(s) that can help with treatment evaluation (Ketamine, Spravato, TMS).**
This is necessary for any insurance authorizations.

Additional Notes (attach if more space is needed)

PLEASE NOTE* For Treatment Evaluation Referral- Patient must bring list of Current & Failed Medications to expediate any Prior Authorizations necessary. (**Must have at least 2 failed mediations (trial dates minimum 4 weeks) for prior authorizations)

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